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MEDICAL MALPRACTICE

Federal Tort Claims Act Coverage Could Reduce Health Centers' Costs

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The Honorable Orrin G. Hatch, Chairman
The Honorable Patrick J. Leahy, Ranking Minority Member
Committee on the Judiciary
United States Senate

The Honorable Thomas J. Bliley, Jr., Chairman
The Honorable John D. Dingell, Ranking Minority Member
Committee on Commerce
House of Representatives

Federally funded community and migrant health centers, which provide health care to over 9 million people regardless of their ability to pay, are facing growing patient populations and increasing financial pressures. To help these 716 centers meet budgetary constraints, the Congress gave them the opportunity to reduce or eliminate their spending for private malpractice insurance, estimated at $50 million in 1994. In the past, centers have typically purchased comprehensive malpractice insurance to protect their physicians and other practitioners against claims. By offering Federal Tort Claims Act (FTCA) coverage to these centers, the federal government has agreed to assume responsibility for malpractice claims against covered centers and their practitioners, if certain conditions are met. The savings realized by centers may be used to expand health services. FTCA coverage was authorized in 1993 for 3 years referred to by the Department of Health and Human Services (HHS) as the demonstration period. This coverage was made permanent by the Federally Supported Health Centers Assistance Act of 1995 (P.L. 104-73).

This act also directed us to review the implementation of FTCA coverage for community health centers. In response, we examined the centers' use of FTCA coverage and determined the status of claims filed against FTCA-covered centers through March 21, 1997. In addition, we reviewed HHS' management of FTCA for community and migrant health centers, and studied its efforts to reduce claims through risk management programs.[1]

To develop our information, we interviewed officials at HHS, including its Health Resources and Services Administration (HRSA), which is charged with administering FTCA coverage for community health centers. We obtained FTCA claims data for covered centers and determined the status of

[1]Risk management programs related to medical malpractice are intended to limit financial losses resulting from allegations of improper patient care. These programs typically include risk identification and assessment, risk prevention and control, and risk monitoring.

these claims. We also interviewed officials from the Department of Justice, 35 community and migrant health centers, and 7 insurers offering malpractice coverage to centers. In addition, we obtained the views of other health care, malpractice, and risk management experts. More details on our scope and methodology are in appendix I. A complete list of the organizations we contacted is in appendix II. We performed our review between March 1996 and March 1997 in accordance with generally accepted government auditing standards.

Results in Brief

The permanent authorization of FTCA coverage, the greater availability of supplemental policies to cover incidents not covered under FTCA, and the reports of some centers already realizing substantial savings have contributed to the willingness of many centers to now obtain FTCA coverage. Although HRSA required centers to apply for FTCA coverage during the demonstration period, centers were not compelled to cancel their private comprehensive malpractice insurance. Although HRSA does not have complete data on center participation during the 3-year demonstration period, it appears that most centers retained their private comprehensive malpractice insurance during this time. Because these centers were covered by both FTCA and their private policies, they did not reduce their insurance costs. Of the 716 centers eligible for FTCA coverage, 452 have elected this coverage and are now required to cancel their private comprehensive malpractice insurance. Despite this level of participation, a significant number of centers have not reapplied for FTCA coverage since its recent extension. As of March 21, 1997, 264 of the 716 centers eligible for FTCA coverage, or 37 percent, had not applied for it.

Since the demonstration period began in 1993, there have been 138 claims filed against FTCA-covered centers alleging damages of more than $414 million. However, the actual amount of the federal government's liability for these claims is unclear. As of March 21, 1997, only five claims have been settled, with total payments of $355,250. Seven others have been disallowed.

At the recommendation of HHS' Office of Inspector General (OIG), HRSA developed a legislative proposal that, if enacted, would limit the federal government's liability to $1 million for claims filed against FTCA-covered centers. Unlike private insurance policies, which limit the insurer's liability, FTCA coverage does not have a monetary limitation. HRSA's proposal is currently under review by the Secretary of HHS. If adopted, this cap would be consistent with the exposure assumed by private carriers

insuring these centers. Of the 126 remaining claims, 59 are seeking payments in excess of $1 million.

By extending FTCA coverage to centers, the federal government has assumed potential liabilities that need oversight and careful management. HHS could improve its administration of FTCA coverage for community and migrant health centers by strengthening data collection efforts and claims management practices. For example, HRSA has not obtained adequate information on the centers' use of FTCA during the demonstration period nor has it gathered sufficient data on the centers' expenditures for malpractice insurance. Without this information, HRSA cannot determine whether centers have reduced their malpractice insurance costs. HHS has 6 months in which to either deny a claim or make a settlement offer before a claimant may file suit in federal court. In some cases, HHS did not contact claimants regarding their claims. For 22 of the 32 claims that have resulted in federal lawsuits, HHS had not attempted to respond to the claimants during this 6-month period.

Risk management services can help centers minimize liability by reducing their financial exposure to claims. Although directed to oversee the implementation of FTCA coverage for eligible centers, HRSA is not required to provide centers with risk management services. Private insurers conduct risk management programs because they believe it helps reduce their exposure to claims and helps maintain an acceptable standard of care. While HRSA is making plans to provide centers with some services, it is not preparing to provide as many of these services as do some private insurers or other federal agencies with FTCA malpractice coverage. Furthermore, HRSA has not implemented a claims-tracking system comparable to those used by other federal agencies and insurers.

Background

Community and migrant health centers are financed in part with federal grants administered by HRSA.[2] HHS awards grants to public and nonprofit entities to plan, develop, and operate health centers for medically underserved populations. To assist in providing health care to these groups, HHS awarded over $750 million in grant assistance in fiscal year 1996.[3]

[2]In fiscal year 1995, these grants constituted 30 percent of health centers' revenue.

[3]Centers may receive these grant funds under any of the following four sections of the Public Health Service Act: (1) section 329—migrant health centers, (2) section 330—community health centers, (3) section 340—health services for the homeless, and (4) section 340A—health services for residents of public housing. To be eligible for FTCA coverage, a center must receive grant funds from one of these four sources.

Like all patients, those receiving care from community or migrant health centers may seek compensation for medical malpractice if they believe the treatment they receive does not meet an acceptable standard of care. Patients may seek payment for economic losses such as medical bills, rehabilitation costs, and lost income; and noneconomic losses such as pain, suffering, and anguish. To obtain protection against malpractice claims before FTCA coverage became available, most centers had purchased private comprehensive malpractice insurance.

The Congress enacted the Federally Supported Health Centers Assistance Act of 1992 (P.L. 102-501) to provide FTCA medical malpractice coverage to community and migrant health centers. This law made FTCA coverage available to grantees for a 3-year period beginning January 1, 1993, and ending December 31, 1995. It provided centers an opportunity to reduce their malpractice insurance expenditures. The Congress extended the availability of permanent FTCA coverage to centers in December 1995. FTCA coverage, which is provided at no cost to the centers, is an alternative to private comprehensive malpractice insurance and gives centers a chance to redirect their savings to the provision of health services. Centers opting for FTCA coverage may decide to purchase a supplemental or "gap" policy to cover events not covered by FTCA. Even with the purchase of a gap policy, HRSA expects that centers will spend less on insurance than they would if they continued to purchase comprehensive coverage.[4]

In a center not covered by FTCA, patients or their representatives would file a malpractice claim with the private carrier insuring the provider. Insurers are generally responsible for investigating claims, defending the provider, and paying any successful claims, up to a stated policy limit. If not resolved by the insurer, a claim could result in a lawsuit filed in state court. In addition to insuring centers against instances of malpractice, insurers may provide risk management services. Private carriers generally view these services as a way to reduce the incidence of malpractice, and in turn, reduce or minimize their liability.

Malpractice claims against FTCA-covered centers are resolved differently from those filed against centers with private insurance. Patients of

[4]In 1993, on the basis of projected estimates, we reported that if all community health centers used FTCA coverage instead of private insurance coverage for the 3 years authorized, the federal government's costs to resolve the centers' FTCA malpractice claims could have been greater than the amount the centers would have spent on insurance coverage. We found the unlimited coverage provided by FTCA could add about 50 percent to the cost of settling claims. This projection was based on actuarial assumptions that subject the results to a significant amount of uncertainty. See Medical Malpractice: Estimated Savings and Costs of Federal Insurance at Health Centers (GAO/HRD-93-130, Sept. 24, 1993).

FTCA-covered centers must file administrative claims with HHS. Claims must be filed within 2 years after the patient has discovered or should have discovered the injury and its cause. Under FTCA procedures, the claim is filed against the federal government rather than against the provider. After reviewing the claim, the HHS Office of General Counsel may attempt to negotiate a financial settlement or, if it finds the case to be without merit, it may disallow the claim.

Claimants dissatisfied with HHS' determination have 6 months to file a lawsuit against the federal government in federal district court. Claimants may also file suit if HHS fails to respond to their claims within 6 months of receipt. If a claim results in the filing of a medical malpractice suit, the Attorney General, supported by the Department of Justice (DOJ), represents the interest of the United States in either settling the case out of court or in defending the case during the trial. If the claim continues to trial, the case is heard in a federal district court without a jury; punitive damages cannot be awarded.

Protection against malpractice claims through FTCA has been provided to federally employed health care providers since 1946, when the government waived its sovereign immunity for torts, including medical malpractice. Prior to this date, individuals were prohibited from bringing a civil action against the federal government for damages resulting from the negligent or other wrongful acts or omissions of its employees acting within the scope of their employment. Since then, the federal government defends malpractice claims made against federal employees practicing medicine at agencies such as the Department of Veterans Affairs, the Indian Health Service, and the Department of Defense, so long as those practitioners were providing care within the scope of their employment.

While FTCA coverage may reduce centers' insurance costs, it imposes a potentially significant liability on the federal government because FTCA does not limit the amount for which the government can be held liable. Private policies generally limit the amount that can be paid on a claim, typically to $500,000 or $1 million. The total amount paid for all claims is also usually limited. For example, a policy with coverage limits of $1 million/$3 million will pay up to $1 million for each claim and no more than $3 million for all claims annually. As FTCA does not specify a monetary

limitation, payments could be substantially higher than the monetary limits of private malpractice insurance policies.[5]

More Centers Plan to Use FTCA Coverage to Reduce Their Costs

While most eligible centers did not rely on FTCA coverage during the demonstration period, centers now seem to be taking greater advantage of the opportunity to reduce their costs. The number of centers relying on FTCA coverage appears to have increased significantly. During the demonstration period, all centers were required to apply for FTCA coverage but did not necessarily cancel their private comprehensive malpractice insurance. As a result, most centers incurred the cost of private insurance during the demonstration period and were not relying on FTCA coverage. As of March 21, 1997, 452 of 716 eligible centers have applied for FTCA coverage. HRSA has told centers to cancel private comprehensive malpractice insurance when they come under FTCA but remains uncertain, as it was in the demonstration period, about which FTCA-covered centers have actually terminated that insurance and are thus not paying for duplicate coverage.

During the demonstration period, many centers were uncertain FTCA coverage would be permanently extended and retained private insurance. Centers feared that converting back to private comprehensive malpractice insurance, if an extension was not enacted, would be both difficult and costly. Others were concerned about the possibility that not all claims would be covered by FTCA. While HRSA permits centers to combine gap policies with FTCA coverage, the expense and difficulty associated with obtaining gap coverage was an additional concern.

The permanent extension of FTCA and provisions in the new law appear to have eased many of the centers' concerns. Since the demonstration began, private insurers have developed more gap policies to insure against incidents not covered by FTCA. The new law made FTCA coverage optional for centers. Centers that do not want FTCA coverage are no longer required to apply for it. In addition, the new law addressed other concerns raised by the centers during the demonstration period. For example, FTCA coverage was expanded to include part-time practitioners in the fields of family practice, general internal medicine, general pediatrics, and obstetrics and gynecology. Centers were also given greater assurance that the federal government would cover their claims. During the demonstration period,

[5]Malpractice suits are generally tried under the law of the state where the alleged incident of malpractice occurred. Some states limit the amount that can be recovered by claimants in malpractice suits, and such a state-imposed cap on damages would apply to court decisions on FTCA claims as well.

DOJ could invalidate HHS' decision to grant a center FTCA coverage after a claim was filed. Now, HHS' decision is binding upon the Attorney General.

The possibility of reducing center costs also influenced many of the center officials with whom we spoke. For example, one center in New England reported its malpractice insurance costs were reduced by almost $600,000 since 1993. A center official there told us that the savings have been used to improve medical staff retention and will also be used to expand patient programs. Another center in the Midwest reported savings of $350,000. Of the center officials we spoke to who now intend to rely on FTCA coverage, all reported the opportunity to reduce costs as the main factor in choosing FTCA over private comprehensive malpractice insurance.

Although FTCA participation appears to have grown substantially since the demonstration period, not all centers have opted for FTCA coverage. Of the approximately 716 centers currently eligible for this coverage, 264 of the eligible centers, or 37 percent of them, have not applied for it. FTCA is still a relatively recent option for centers and some center personnel may be questioning the desirability of this coverage for their facility. Uncertainty about which practitioners and services are not covered by FTCA, the availability of private policies to cover any gaps, and questions about the FTCA claims resolution process may all contribute to a center's decision to retain private coverage. Center officials from two southern states told us that their malpractice premiums were low enough that there was little incentive to convert to FTCA coverage. Officials from other centers that do not have FTCA coverage told us that resistance from the medical staff and the loss of tailored risk management services are also contributing factors in their decision to keep private insurance.

Few FTCA Health Center Claims Resolved to Date

Few of the 138 FTCA claims filed against health centers since the beginning of FTCA coverage have been resolved. Although the number of FTCA claims filed against centers has increased since the demonstration period began in 1993, only five settlements have been made and all have been relatively small. Table 1 shows the number of claims filed and compensation sought and awarded by fiscal year.

Table 1: Number and Dollar Amount of FTCA Claims Filed and Settled for Community and Migrant Health Centers

Fiscal year	Number of claims	Amount claimed	Claims settled[a]	Amount paid
1994	4	$5,950,000	1	$5,250
1995	18	66,327,000	2	325,000
1996	76	252,467,470	2	25,000
1997[b]	40	90,055,003	0	0
Total	**138**	**$414,799,473**	**5**	**$355,250**

[a]Claim settlement information is displayed according to the year the claim was filed. This is not necessarily the year in which the claim was actually settled.

[b]Through Mar. 21, 1997.

In addition to the five claims that have been settled, seven others have been disallowed by HHS. The total amount of compensation sought by the 126 remaining claimants is in excess of $400 million. Thirty-two FTCA claims have resulted in lawsuits that have been filed in federal court. The 94 remaining claims are pending in HHS.

Current claims and settlement experience may not be an accurate indicator of future claims. Although claim payments to date have been relatively small, one large settlement or court award could dramatically increase the total.[6] Other factors also make it difficult to predict future payments. There may be a time lag between alleged instances of malpractice and claim filings, as claimants have 2 years from the date of the alleged incident to file a claim. However, a prior analysis of claims reported by centers before the demonstration period showed that their claims experience was considered favorable by actuaries in relation to the insurance premiums they paid.[7]

HRSA Recommends Capping Payments Made on Behalf of FTCA-Covered Centers to Limit Federal Liability

HRSA has drafted a legislative proposal limiting the federal government's liability for FTCA claims filed against migrant and community health centers. This proposal, initially recommended by HHS' OIG and currently under review by the Secretary of HHS, calls for capping the amount a claimant may seek in damages from an FTCA-covered center at $1 million.[8]

[6]For HHS medical malpractice claims against federal employees and paid under FTCA in calendar years 1986 through 1996, the largest administrative settlement was $975,000 (paid in 1989), and the largest federal court case payment was $5.7 million (paid in 1986).

[7]GAO/HRD-93-130, Sept. 24, 1993.

[8]Department of Health and Human Services, Office of Inspector General, Cost to the Government for Providing Medical Malpractice Coverage to Community and Migrant Health Centers (Washington, D.C.: Mar. 25, 1996).

This would be comparable with the $1 million cap per claim that private insurance carriers typically place on malpractice policies, including those sold to health centers. If enacted, this proposal would, for the first time, limit the federal government's liability under FTCA and would be an exception for only federally funded health centers. According to HHS' OIG report, this cap could save the federal government as much as $30.6 million over a 3-year period, if all health centers elected FTCA coverage. Of the 126 unresolved FTCA claims, which include the 32 pending lawsuits, 59 seek compensation in excess of $1 million.

Management of FTCA Coverage Could Be Improved

HRSA's collection of FTCA participation data has been limited. This information is necessary to determine whether FTCA coverage is reducing health centers' costs and is also critical to the agency's ability to provide risk management. Although HRSA has attempted to collect data related to centers' use and savings under FTCA, these attempts have not been effective. HHS has also failed to respond to claimants in a timely manner, which gives them the opportunity to file lawsuits in federal court. While HRSA intends to provide centers with some risk management services, it has not developed a comprehensive risk management plan and presently does not intend to provide some of the important risk management activities currently provided by private insurers and other federal agencies.

HRSA's Data Collection and Claims Management Are Ineffective

HRSA cannot accurately report the amount centers spent on comprehensive private malpractice insurance during the FTCA demonstration period, nor can the agency report with certainty the total cost reductions realized by FTCA-covered centers during that period. HRSA officials were unable to identify those centers that canceled these comprehensive policies during the demonstration period and relied on FTCA coverage. Although HRSA collected data from centers regarding their insurance costs and savings under FTCA, we found that these data were not reliable for determining whether centers canceled their private comprehensive malpractice insurance and reduced their costs. The form HRSA provided to centers was not accompanied by instructions. In addition, the form did not provide centers with a means of reporting and identifying all of their malpractice insurance expenditures. Consequently, centers may have supplied inappropriate data or reported expenditures inaccurately while other information, critical to determining actual cost reductions, was not obtained. Without reliable information on centers' reliance on FTCA it will be difficult for HRSA to target its limited risk management services on

FTCA-covered centers. Similarly, without sound data on cost reductions, HRSA will be unable to determine if coverage under FTCA saves centers money.

HRSA is now taking steps to end dual coverage, which has hampered HRSA's data collection efforts and oversight of FTCA. While HRSA advised centers in April 1996 that they must choose between FTCA coverage and private comprehensive malpractice insurance, it did not establish a date after which duplicate insurance will no longer be an allowable charge to the grant at centers with FTCA coverage. We spoke with officials at 27 centers with FTCA coverage. Of those 27 centers, 6 were also covered by private comprehensive malpractice insurance. We subsequently advised HRSA that a deadline was needed to ensure that health centers reduce their costs by terminating duplicate coverage. HRSA officials agreed and recently issued a directive to FTCA-covered centers to cancel their private comprehensive malpractice insurance by March 31, 1997.

In many cases, HHS has not contacted claimants regarding their claims, and some claimants have filed suit in federal court. Claimants are precluded from filing suit for 6 months unless HHS has denied the claim. For 22 of the 32 claims involving FTCA-covered centers that have resulted in federal lawsuits, HHS had not responded to the claimants or contacted them to discuss a settlement during the 6-month period. HHS officials told us that in many cases they had been unable to obtain documentation and medical reviews needed to assess the merits of these claims and were therefore not prepared to either settle or deny them. DOJ is now responsible for representing the government in these lawsuits. If HHS had achieved a settlement in any of these cases, some of the costs of FTCA administration associated with involving another federal agency, preparing for trial, and defending the case in court might have been avoided.

HRSA Planning to Offer Limited Risk Management Services

Risk management provides an opportunity to limit financial losses resulting from allegations of improper patient care. It also offers providers a way to improve service to patients, avoid patient injuries, and reduce the frequency of malpractice claims. The health care experts we spoke with consistently promoted risk management as a tool to simultaneously minimize loss and improve the quality of patient care. Although the law extending FTCA coverage to centers does not direct HRSA to provide risk management, HRSA officials acknowledge both the need to minimize the federal government's potential liability and provide risk management services to centers. HRSA has begun to provide centers with some of these

services. However, HRSA is not planning as extensive a risk management program as some private insurance carriers or other federal agencies with FTCA malpractice coverage, such as the Department of Defense and the Indian Health Service. (App. III provides more details on the purpose and potential benefits of risk management for health care facilities.)

A wide range of risk management services was offered to health facilities and practitioners by the insurance companies and federal agencies we interviewed. While some provided extensive services—including site inspections, periodic risk reassessments, and telephone hotlines to respond to center concerns—others offered these services on request or to larger facilities. The more commonly offered services included claims tracking, analysis, and feedback on specific incidents, educational seminars, risk management publications, and the opportunity to obtain specific guidance on center concerns.

Most of the health center officials we spoke with valued their insurer's risk management services. Many regarded the opportunity to discuss a new procedure or a potential malpractice claim with a risk manager as the most important feature of their insurer's risk management plan. Several officials said they were reluctant to cancel private comprehensive malpractice coverage in favor of FTCA because they would then lose the risk management services they have come to rely upon. In contrast, other centers find risk management services are still available from their private insurer if they purchase a supplemental policy to cover gaps in FTCA coverage. Additionally, HRSA has advised centers that the purchase of private risk management services by centers will be an allowable charge to their grant.

Recently, HRSA has begun to take steps to provide centers with risk management. HRSA has contracted with the National Association of Community Health Centers (NACHC) to provide telephone consultations with centers regarding FTCA and risk management issues. NACHC may also provide a limited number of special risk management seminars to centers through HRSA-sponsored training. HRSA officials told us that they will obtain a subscription for all FTCA-covered centers to the Armed Forces Institute of Pathology's annual publication, Open File, which is exclusively devoted to risk management issues. Individually tailored risk management assessments may also be offered to centers through HRSA's Technical Assistance Program. This assistance would supplement the agency's periodic site inspections of centers, already a routine component of its grant management process.

While HRSA has taken important steps in providing centers with some risk management services, some critical risk management activities—performed by other insurers, including other federal agencies—have been excluded from its efforts. For example, it has not established a policy for providing centers with specific feedback based on their claims experience nor has it instituted a useful claims tracking system, widely regarded by risk management experts as an essential component of managing risk. The experts we spoke to told us that a tracking system provides a way of identifying problem practitioners as well as patterns among practitioners and facilities. While HRSA officials agreed with the importance of these risk management activities, they told us that the initial activities related to the implementation of FTCA for health centers necessarily took priority over the development of a comprehensive risk management plan.

Conclusions

Community and migrant health centers are being challenged by increasing financial pressures, jeopardizing their service to large medically needy populations. By opting for FTCA coverage, centers can reduce their malpractice insurance expenditures and redirect these funds to providing needed services to their communities.

Malpractice coverage provided by FTCA differs in many ways from that provided by private malpractice insurance coverage. One of the significant differences is the lack of a monetary limitation on liability coverage, which could play a signiftcantant role in determining the federal government's ultimate cost of providing FTCA coverage to community and migrant health centers and which heightens the importance of a sound risk management plan.

As more centers rely on FTCA for malpractice coverage, the federal government's potential liability will increase as will the need for risk management. Insurers and other federal agencies have employed a variety of risk management practices to limit liability and improve clinical practices. The growth in FTCA coverage offers both the challenge of a greater federal liability to manage and a new opportunity to help community and migrant health centers improve the quality of their care.

Recommendations

We recommend that the Secretary of Health and Human Services direct the Administrator of HRSA to develop a comprehensive risk management

plan, including procedures to capture claims information and to identify problem-prone clinical procedures, practitioners, and centers.

Agency Comments

We provided HHS an opportunity to comment on a draft of this report, but it did not provide comments in time for inclusion in the final report. However, program officials provided us with updated claims information and also offered several technical comments based on their review of the draft report, which we have incorporated as appropriate. In addition, we also discussed the findings presented in this report with program officials who generally agreed with the facts we presented and with our evaluation of HRSA's management of FTCA coverage for community health centers.

We are sending copies of this report to the Director of the Office of Management and Budget, the Secretary of Health and Human Services, and interested congressional committees. We will make copies available to others upon request. Major contributors include Paul Alcocer, Geraldine Redican, Barbara Mulliken, and Betty Kirksey. Please call me at (312) 220-7767 if you or your staff have any questions concerning this report.

Leslie G. Aronovitz
Associate Director, Health Financing
and Systems Issues

Contents

Abbreviations

AFIP	Armed Forces Institute of Pathology
DOJ	Department of Justice
FTCA	Federal Tort Claims Act
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
NACHC	National Association of Community Health Centers
OIG	Office of Inspector General
PIAA	Physician Insurers Association of America

Scope and Methodology

To review HHS' implementation of FTCA coverage for community health centers, we spoke with officials from HRSA's Bureau of Primary Health Care in Bethesda, Maryland, as well as the agency's regional FTCA coordinators. To assess the FTCA claims resolution process and to determine the status of claims filed, we met with and obtained data from the Public Health Service Claims Office, HHS' Office of General Counsel, and DOJ. However, we did not independently verify the status of these claims. To obtain information on why community health centers do and do not participate in the FTCA program, we interviewed officials from the National Association of Community Health Centers (NACHC) and three state primary care associations. We also interviewed officials from 35 community health centers, including 27 centers with FTCA coverage and 8 centers that were not participating in the FTCA program.

To determine the types of risk management services provided to community health centers, we interviewed representatives of seven insurers and three risk management consulting firms providing these services. We also discussed these services with some of the community health center officials we interviewed. We identified the insurance carriers through discussions with HRSA officials in both headquarters and regional offices, community health centers, NACHC, and others knowledgeable about the malpractice market. We selected carriers selling malpractice insurance in a variety of geographic areas, including both coasts, the midwest, and the south. We also selected carriers with significant experience insuring community health centers. We estimate that collectively, these carriers have insured over 300 community health centers against malpractice claims. We also discussed the unique risk management needs of community health care centers with a variety of health care experts. In addition, we contacted the Armed Forces Institute of Pathology and the Indian Health Service to discuss their risk management programs.

Organizations Contacted

Risk Management Experts and Consultants

Accreditation Association for Ambulatory Health Care, Inc.
American Society for Healthcare Risk Management
American Medical Association
Illinois Risk Management Services
Joint Commission on Accreditation of Healthcare Organizations
MMI Companies, Inc.
Physician Insurers Association of America
QA/RM Consultants
S. A. Gross & Associates

Malpractice Insurers

Clinic Mutual Insurance Co.
Frontier Insurance Group, Inc.
Healthcare Underwriters Mutual Insurance Company
PICOM Insurance Company
Risk Management Foundation of the Harvard Medical Institutions, Inc.
The St. Paul Companies, Inc.
Washington Casualty Company

Government Agencies

Armed Forces Institute of Pathology
Department of Health and Human Services
- Health Resources and Services Administration
- Indian Health Service
- Office of the General Counsel
- Office of Inspector General
- Public Health Service

Department of Justice

Community Health Centers

Alcona Citizens for Health, Inc. (MI)
Barnes-Kasson County Hospital (PA)
Brownsville Community Health Center (TX)
Citizens of Lake County for Health Care, Inc. (TN)
Columbia Valley Community Health Services (WA)
Country Doctor Community Clinic (WA)
Crusaders Central Clinic Association (IL)
Detroit Community Health Connection, Inc. (MI)
East Arkansas Family Health Center, Inc. (AR)
El Rio Santa Cruz Neighborhood Health Center, Inc. (AZ)
Erie Family Health Center, Inc. (IL)
Grace Hill Neighborhood Health Center (MO)

Greater New Bedford Community Health Center, Inc. (MA)
Indian Health Board of Minneapolis, Inc. (MN)
Kitsap Community Clinic (WA)
La Clinica de Familia, Inc. (NM)
La Clinica del Pueblo de Rio Arriba (NM)
Lamprey Health Care, Inc. (NH)
Laurel Fork-Clear Fork Health Centers, Inc. (TN)
Lawndale Christian Health Center (IL)
Manet Community Health Center, Inc. (MA)
Memphis Health Center, Inc. (TN)
Missoula City/County Health Department (MT)
Model Cities Health Center, Inc. (MN)
Ossining Open Door Health Center (NY)
Perry County Medical Center, Inc. (TN)
Presbyterian Medical Services (NM)
Providence Ambulatory Health Care Foundation, Inc. (RI)
Sea Mar Community Health Center (WA)
Shawnee Health Service Development Corporation (IL)
Southern Ohio Health Services Network (OH)
South Plains Health Provider Organization, Inc. (TX)
Southwest Community Health Center, Inc. (CT)
The Clinic in Altgeld (IL)
Westside Health Services, Inc. (NY)

Community Health Center Organizations

Illinois Primary Health Care Association
National Association of Community Health Centers, Inc.
Massachusetts League of Community Health Centers
Michigan Primary Care Association

Risk Management Is Intended to Minimize Financial Losses and Improve Care

Risk management offers physicians and other health care practitioners and facilities a means of improving patient services, avoiding patient injuries, and reducing the frequency of malpractice claims. Organizations such as the American Medical Association, the American Hospital Association, the Joint Commission on the Accreditation of Healthcare Organizations, and the Physician Insurers Association of America (PIAA) recognize risk management as an effective tool for minimizing liability and enhancing quality care. The insurers and health care experts we spoke with concurred that risk management provides the underwriter or, in the case of FTCA coverage, the federal government, the possibility of preventing instances of malpractice from occurring and thereby reducing financial liability. They also told us that risk management can help educate physicians and other medical personnel while improving their performance. Many of the center officials we spoke with also valued risk management services.

The insurance industry and federal officials we spoke with consistently underscored claims tracking and analysis as one of risk management's most critical components. Claims tracking and analysis provides a way of identifying patterns in the types of malpractice claims filed against providers. This information may be used to identify facilities or practitioners that pose risks and problem-prone clinical practices. It can also be key to implementing corrective actions, such as selecting a practitioner or an entire facility for other risk management services.

Aggregating and analyzing claims data and sharing results with health care providers may reduce the number of claims by bringing to light factors that lead to claims. Analyzing claims made and settled is done by individual insurers, organizations representing groups of insurers, such as PIAA, and federal agencies administering health programs FTCA covers for malpractice claims.

Many insurers collect medical malpractice data. Data collected may relate to the cause of claims and their severity, the amounts requested and paid by type of injury, and demographic features of claimants and providers. For example, PIAA, which represents physician-owned or -directed professional liability insurance companies, routinely collects and analyzes data from 21 of its member companies. PIAA has issued special reports on topics such as lung cancer, medication errors, and orthopedic surgical procedures. This information can alert providers to situations that may put them at greater risk for a malpractice claim and increase their awareness of new or continuing problem areas.

The federal government also recognizes the value of analyzing claims data as both a risk management tool and a means of improving quality care. The Armed Forces Institute of Pathology (AFIP) performs detailed claims analysis for all branches of the military and other federal agencies, such as the Department of Veterans Affairs, that are covered by FTCA. In addition to conducting studies, AFIP also provides direct feedback and responds to queries from facilities seeking to improve performance and minimize risk. The Indian Health Service (IHS) provides health care services at both hospitals and outpatient facilities. IHS performs its own analysis of claims, although on a smaller scale than AFIP. IHS has tracked claims for 10 years and provides routine feedback to all facilities and practitioners after a claim has been resolved. It has also created a database of all filed claims and has issued reports of its analysis to IHS facilities.

Ordering Information

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